EBD Health Insurance Change Form:

Please complete form and return to the HR Manager to process your request. This form should be used for the following changes:

- To add or delete dependents from health insurance plan during open enrollment or during the plan year according to Cafeteria Plan rules which may allow a change in coverage status, i.e. Employee Only, Employee & Spouse, etc.
- To indicate the reason for making a change such as birth of a child, marriage, etc.
- To change mailing address or name.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your request.

Section 1: Employee Information

Please provide the demographic information requested.

- If not previously provided, please print your email address if you would like to receive benefit updates and information mailed to you as the need arises.
- Primary Care Physician information is only required for members of the HMO or POS plans. DO NOT list a PCP if you are enrolled in the PPO plan.

Section 2: Change in Dependent Status

Complete this section if you want to add or delete a dependent from the plan.

- Provide complete information for each dependent.
- Please provide Social Security Number of the dependent, date of birth and whether the intent is to "add" or "delete" them from the policy.
- If dependents are being DELETED from the policy, it is not necessary to indicate PCP, PCP #, or Student Status. If you are ADDING a dependent, please complete all of the requested information.
- If dependent(s) is/are age 19 or older, they must be a full-time student to continue on the insurance. Please indicate whether they are a full-time student. You must also submit a Student Verification Form to the HR Manager. This form can be obtained in the HR Office, or you may download a copy via EBD's website at www.arbenefits.org. You will find the form on the Benefits Library Link.
- If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents being added to the policy.
- If you have more dependents than space allows, please attach an additional sheet containing the required information.

Section 3: Change in Coverage

Please complete this section to make any of the changes listed. Also provide a reason for the change, along with the date of the change.

- Address changes can be indicated as "other" for reason of change.

Section 4: To be completed by Agency

Do not complete this section. The HR Office will complete the information.

Employee Signature:

Sign and date the form on the lines provided. It is recommended that you make a copy of this form for you records.

! Don't forget to return the form and any necessary attachments to the HR Manager to be processed.

Note: if this change is for open enrollment, you must submit the form to the HR Office no later than October 31st. Changes will not take effect until January 1st.

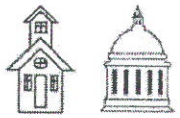
STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.state.ar.us/dfa/ebd

Change Form

Status, Name and Address



1. Employee Information: (please print)					
Last Name	First Name			MI	☐ Married ☐ Single
Home Address	City		State	Zip Code	
SSN#	Date of Birth:	Home #:		Work #:	
If you would like benefit information sent to you by email, please print your email address:					
Primary Care Physician:		PCP #		Current patient?	

2. Change in Dependent Status (complete this portion if making any changes in dependent status):			
FIRST NAME	LAST NAME	MI	GENDER
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
****For dependents 19 and over only. Please submit proof of student status.**

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
☐ Employee Only ☐ Add Dependent ☐ Employee & Spouse ☐ Delete Dependent ☐ Employee & Children ☐ Name ☐ Family ☐ Address ☐ Cancel Coverage	☐ Birth - Date: _____ ☐ Death - Date: _____ ☐ Divorce - Date: _____ ☐ Marriage* - Date: _____ ☐ Other: _____

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ **Date:** _____